STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155761	A. BUILDING 00 B. WING	04/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Recertification and State Licensure survey. This visit included the Investigation of Complaint IN00104573. Complaint IN00104573- Unsubstantiated due to lack of evidence. Survey dates: April 9, 10, 11, 12, 13, 16 and 17, 2012 Facility number: 011367 Provider number: 155761 AIM number: 200851590 Survey team: Leia Alley, RN, TC Patty Allen, BSW Marcy Smith, RN Dinah Jones, RN Census bed type: SNF 19 SNF/NF 113 Residential 10 Total: 142 Census payor type: Medicare 30 Medicaid 74 Other 38 Total: 142	F0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVIEW on or after May 17, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on April 23, 2012 by Bev Faulkner, R.N.			

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F0223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure that residents were free from abuse for 1 of 10 residents interviewed of the 51 who resided on the 400 Hall. (Resident # 80) Findings Include: On 4/10/2012 at 02:24 p.m., an interview with Resident #80 indicated she had been treated roughly by a male staff member. Resident #80 indicated "Sometimes the male CNAs are rough." She indicated she believes one male aide fondled her because he held her too closely to his body and for too long when he assisted in transferring her from her bed to her wheelchair. She also indicated one CNA came into her room and indicated, "All you do is sleep and poop." The Resident indicated, "They blame me when the toilet stops up."	F0223	**F223 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A meeting was held with Resident # 80. When asked if she has ever been treated badly here she states "no". However, further discussion reveals she thinks all males that work here are here for sexual reasons. We have added to her care plan she is not to have male caregivers if at all possible. Due to the fact this resident had not informed us of any prior concerns with this issue, she was educated on how to report any complaints that she has. Resident states sometimes she "just gets these things in her head." She has been referred for counseling and psychological evaluation on this issue. During meeting resident could not think or describe any other employee she is fearful of and states she likes living here. Her psychological evaluation showed diagnosis of dementia, parnoid personality disorder, rule out delirium, and history of false	05/17/2012

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	She indicated she is fearful of all the CNAs working on the 400 Hall. 4/12/12 at 10:14 a.m., a review of the facility's policy entitled "Abuse Prohibition, Reporting and Investigation Policy and Procedure," dated February 2010, provided by the Executive Director indicated the definition of abuse as, "the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical mental or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish." 3.1-27(b)		allegations. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. A resident interview has been developed and will be administered to assure no other residents feel this way. Appropriate action according to policy will be taken if any other concerns are expressed. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** During this interview process all residents will be informed on how to report any concern that they have to their customer service representative that is assigned to them. The DNS and/or designee will conduct a staff in-service on abuse, abuse prevention, and reporting of abuse on May 5 th , 6 th , 15 th , 2012 and ongoing. During Resident council, there will be additional discussion on how to voice any concerns to any staff member at any time. All new residents with will be informed on how to report concerns through their customer service representative. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur**	

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			i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/ Designee is responsible for completion of the abuse CQI tool, weekly x 4 weeks, bimonthly x 2 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.	

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record	F0225	**F225 1. What corrective actions will be accomplished for those residents found to**	05/17/2012

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	review, the facility failed to report allegations of abuse for 1 of 10 residents interviewed in a sample of 51 residing on the 400 Hall. (Resident # 80) Findings Include: The record of Resident # 80 was reviewed on 4/13/2012 at 11:00 a.m. A Social Service Progress Notes, dated 2/22/12, included documentation of an interview with Resident # 80 by the SSA [Social Services Assistant]. Resident #80 indicated people yelled at her and made her feel stupid. When asked if she wanted her (SSA) to talk to people, the resident indicated she did not since she felt that would make the situation worse. On 4/17/12 at 10:50 a.m., an interview with the Executive Director [ED] indicated she was on vacation the week the resident spoke with the SSA concerning how "people yell at me and make me feel stupid" and was unaware of the interview. No investigation had been initiated of which she was aware. On 4/17/12 at 12:30 p.m., an interview with the SSA indicated she		**have been affected by the deficient practice?** Resident #80 has a long document behavioral care plan for yelling out in the dining room when she wants something or yelling out when staff provides care/attention to others. All staff have been educated when she is yelling in the dining room wanting something they are to walk over to her table to respond instead of trying to answer her from across the room as she feels she is being yelled back at and hurts her feelings. The SSA has completed additional training on May 3, 2012 by the Executive Director on how to report, investigate, and document a complaint properly **2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction actions will be taken?** All residents have the potential to be affected. The DNS and/or designee will conduct a staff in-service on abuse, abuse prevention, and reporting of abuse on May 5 th , 6 th , 15 th , 2012 and ongoing. All potential allegations of abuse will be reported timely to the Director of Nursing and Executive Director for investigation and reporting per our policy. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Any	

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	spoke with the resident's nurse regarding the resident's concern about being yelled at, and requested the staff not speak from across the room but walk over to the resident and speak to her closely so the resident could hear what the staff was saying. The SSA indicated she had completed a Resident/Family Concern/Grievance Form, dated 2/22/12, but had not followed up on the complaint with her Supervisor or ED. When questioned, the SSA was able to quote the Facility Policy on abuse protocol, naming 5 types of abuse, to whom to report suspicion of abuse and when to report it (immediately). She indicated she did not follow up with any staff member regarding resident complaint. On 4/17/12 at 12:40 p.m., the SSA was accompanied to the Director Of Nursing's (DON) office to obtain the Grievance Form. The DON indicated she had just received the form and did not have knowledge of the resident's grievance on 2/22/12 before 4/17/12 at 11:45 a.m. The form was signed by the SSA but was not signed by the Director of Social Services nor the Executive Director.		grievance alleging abuse will be investigated immediately per abuse protocol. Grievances will be daily by ED/Designee. The DNS and/or designee will conduct a staff in-service on abuse, abuse prevention, allegations of abuse, and reporting of abuse on May 5 th , 6 th , 15 th , 2012 and ongoing. All potential allegations of abuse will be reported timely to the Director of Nursing and Executive Director for investigation and reporting per our policy. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur (i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/ Designee is responsible for completion of the abuse CQI tool, weekly x 4 weeks, bimonthly x 2 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.	

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	The SSA acknowledged she had kept the form on her desk since 2/22/12 and had not followed up on Resident #80's allegation. 3.1-28(c) 3.1-28(e)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their written policy on reporting abuse for 1 of 10 residents interviewed in a sample of 51 residing on the 400 Hall. Resident # 80 Findings Include: On 4/13/12 at 11:00 a.m., the clinical record of Resident # 80 was reviewed. A Social Service Progress Note, dated 2/22/12,, included documentation of an interview with Resident #80 conducted by the SSA. The resident indicated people yelled at her and made her feel stupid. When asked if she wanted her (SSA) to talk to people, the resident indicated she did not since she felt that would make the situation worse. On 4/17/12 at 10:50 a.m., an interview with the Executive Director	F0226	**F226 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #80 has a long document behavioral care plan for yelling out in the dining room when she wants something or yelling out when staff provides care/attention to others. Her care plan was updated to show when she is yelling in the dining room wanting something staff are to walk over to her table to respond instead of trying to answer her from across the room as she feels she is being yelled back at and hurts her feelings. Her psychological evaluation showed diagnosis of dementia, parnoid personality disorder, rule out delirium, and history of false allegations. The SSA has completed additional training on May 3, 2012 by the Executive Director on how to report, investigate, and document a complaint properly. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction actions will be taken?** All	05/17/2012

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	[ED] indicated she was on vacation the week the resident spoke with the SSA concerning how "people yell at me and make me feel stupid" and was unaware of the interview. No investigation had been initiated of which she was aware. On 4/17/12 at 12:30 p.m., an interview with the SSA indicated she spoke with the nursing staff, regarding the resident's concern about being yelled at and requested they not speak from across the room, but walk over to the resident and speak to her closely so the resident could hear what staff was saying. The SSA indicated she had completed a Resident/Family Concern/Grievance Form, dated 2/22/12, but had not followed up on the complaint with her Supervisor or ED. On 4/17/12 at 12:40 p.m., the SSA was accompanied to the Director Of Nursing's (DON) office to obtain the Grievance Form. The DON indicated she had just received the form and did not have knowledge of the resident's grievance on 2/22/12 before 4/17/12 at 11:45 a.m. The form was signed by the SSA, but was not signed by the Director of Social		residents have the potential to be affected. The DNS and/or designee will conduct a staff in-service on abuse, abuse prevention, and reporting of abuse on May 5 th , 6 th , 15 th , 2012 and ongoing. All potential allegations of abuse will be reported timely to the Director of Nursing and Executive Director for investigation and reporting per our policy. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Any grievance alleging abuse will be investigated immediately per abuse protocol. Grievances will be daily by ED/Designee. The DNS and/or designee will conduct a staff in-service on abuse, abuse prevention, allegations of abuse, and reporting of abuse on May 5 th , 6 th , 15 th , 2012 and ongoing. All potential allegations of abuse will be reported timely to the Director of Nursing and Executive Director for investigation and reporting per our policy. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur (i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/ Designee is responsible for completion of the abuse CQI tool, weekly x 4 weeks, bimonthly x 2 months, and quarterly until continued compliance is	

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	Services or the Executive Director. The SSA acknowledged she had kept the form on her desk since 2/22/12 and had not followed up on Resident #80's complaint. 4/12/12 at 10:14 a.m., a review of the facility's policy entitled "Abuse Prohibition, Reporting and Investigation Policy and Procedure," dated February 2010, provided by the Executive Director indicated the definition of abuse as, "the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical mental or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish." Point #5 on page 2 entitled, "Policy and Procedure" indicated, "all abuse/allegations of abuse must be reported to the Executive Director immediately, and to the resident's representative (sponsor, responsible party) within 24 hours of the report. Failure to report will result in		maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.	

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	disciplinary action, up to and including immediate termination. 3.1-28(a)			

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F0241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure residents and their belongings were treated with respect and dignity related to residents wandering into rooms and going through belongings and staff to resident interaction. This affected 7 of the 51 residents living on the 400 unit at the time of survey. This affected Residents # 's 66, 3, 54, 129, 123, 80, 275 and involved Resident # 's 44 and 280. Findings Include: 1) During an interview with Resident #66 on 4/9/12 at 2:45 p.m., Resident #66 indicated that other residents (Residents #44 and 280) wander into her room any time they want and at times went through her belongings. She indicated that there are a couple of residents that wander from room to	F0241	**F241** **1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #44 and #280 were reported to have entered other resident's rooms and went through their personal belongings. Resident #44 was discharged from the facility 1/26/12 and would not have been present during the survey to have been observed doing anything. No identifying information was left for a resident #280. The facility is aware of another resident with dementia who does wander and her familyhas moved them to a secured dementia unit. Employee #1, who allegedly whistled at a resident, was stopped by the surveyor and Employee #1 stated she was not whistling. Resident #275 when interviewed states they does not recall anyone whistling at them. A meeting was held with Resident # 80. When asked if she has ever been	05/17/2012

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	room, but that one resident (Resident #44) is constantly wandering. Resident #66 indicated the facility tried to resolve the issue but were not able to. 2) During an interview with Resident #3 on 4/10/12 at 1:30 p.m., Resident #3, indicated there are people who have dementia that are free to roam around the building and will wander into her room. Resident #3 indicated she was particularly bothered by Resident #44 because she has "tore up" things that belong to her such as books and puzzles, and she has knocked things on to the floor when she has roamed into the room. Resident #3 also indicated that sometimes she is able to move Resident #44 's wheel chair out of the room, but that Resident #44 can be very strong and sometimes won't move. Resident #3 also indicated that at times it is "scary" when Resident #44 roams into her room because she is strong and does not know what she is doing. Resident #3 indicated there have been times when Resident #44 has roamed into her		treated badly here she states “no”. However, further discussion reveals she thinks all males that work here are here for sexual reasons. We have added to her care plan she is not to have male caregivers if at all possible. Due to the fact this resident had not informed us of any prior concerns with this issue, she was educated on how to report any complaints that she has. Resident states sometimes she “just gets these things in her head.” She has been referred for counseling and psychological evaluation on this issue. During care plan resident could not think or describe any other employee she is fearful of and states she likes living here. Her psychological evaluation showed diagnosis of dementia, parnoid personality disorder, rule out delirium, and history of false allegations. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction actions will be taken?** All residents have the potential to be affected. The DNS and/or designee will conduct a staff in-service on dignity on May 5 th , 6 th , 15 th , 2012 and ongoing. The facility will	

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	room in early morning hours while Resident #3 and her roommate are asleep and it is "scary to wake up with someone wandering in your room and going through your stuff. " Resident #3 indicated there was a time when Resident #44 hit her on the arm before and there are times she will resist staff and other residents that try to remove her from a place she doesn't belong. Resident #3 indicated that Resident #280 does wander into her room often; however, she had the most "problems" with Resident #44. Resident #3 indicated the facility suggested a door bell or stop sign to put on the door to try to keep residents that wander out of the rooms, but they didn't do it. Resident #3 also indicated the facility told the residents "that could be any of us someday" and that the residents that wander around the building have the right to do so. 3) During an interview with Resident #54 on 4/11/12 at 9:20 a.m., Resident #54 indicated there are people who are able to roam around and enter her room. She indicated that she had		still continue to offer all resident stop signs for their doors or motion detectors for their rooms. Every month in resident council, we will ask residents again if they have any concerns regarding dignity. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DNS and/or designee will conduct a staff in-service on dignity on May 5 th , 6 th , 15 th , 2012 and ongoing. The facility will still continue to offer all resident stop signs for their doors or motion detectors for their rooms. Every month in resident council, we will ask residents again if they have any concerns regarding dignity. Facility will address all concerns immediately. Residents will be encouraged to voice any concerns to their customer service representative or any other staff. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur (i.e., what quality assurance program will be put into place?**	

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	her personal belongings gone through by Resident #44 who enters her room on a regular basis. Resident #54 indicated she is not afraid of the residents that wander into her room; however, it really bothered her to come into her own room and see another person going through her things. Resident #54 indicated the facility did not try to fix the situation with the residents that wander into their rooms. Resident #54 indicated that "we were told their doctors say it's ok for them to wander around, so we just have to deal with it and that it could be any of us some day. " 4) During an observation on the afternoon of 4/11/12, and in the presence of the 400 Hall Unit Manager, Resident #129 was seen pushing Resident #44 in a wheel chair up the hall way to the nurses station. Resident #129 looked at the Unit Manager and stated "she was in our room" and turned to walk back to her room. Resident #129 and #123 are room mates and Resident #44 was taken out of their room to the nurses station by Resident #129.		To ensure compliance, the Social Service Director/Designee is responsible for completion of the dignity CQI tool, weekly x 4 weeks, bimonthly x 2 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.	

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	5) During an observation on 4/17/12 at 12:40 p.m., Employee #1, CNA (Certified Nurses Assistant) was observed whistling at Resident #275, who was sleeping, as to get her attention and yelled to the resident as she was walking quickly past the resident "Hey [Name of Resident #275] it's time for lunch!" 6) On 4/10/2012 at 02:24 p.m., an interview with Resident #80 indicated she had been treated roughly by a male staff member. Resident #80 indicated "Sometimes the male CNAs are rough." She indicated she believes one male aide fondled her because he held her too closely to his body and for too long when he assisted in transferring her from her bed to her wheelchair. She also indicated one CNA came into her room and indicated, "All you do is sleep and poop." The resident indicated, "They blame me when the toilet stops up." The resident indicated the CNAs didn't introduce themselves when coming into her room and didn't want to tell her their names when she			

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	asked who they were, indicating "Why do you want to know? Are you going to get me in trouble?" The resident also indicated the staff walk up behind her and start pushing her in her wheelchair without letting her know who they are. The resident was unable to identify specific names of staff and indicated concerns are during all shifts and she often was made to wait 45 minutes to an hour after using her call light for assistance. She indicated the night shift was the worst and there were nights when no one came to check on her all night and she would be wet, from being incontinent, up to her neck by morning. On 4/10/12 at 2:45 p.m., a record review of the Quarterly Minimum Data Set, dated 3/11/12, indicated Resident #80's Brief Indicator of Mental Status [BIMS] Cognition Score was 14 of a total of 15 indicating a high level of cognitive function. On 4/10/12 at 3:17 p.m., an interview with Resident #80 indicated the staff were rude and disrespectful when providing care for her. When asked if all staff were rude and disrespectful she indicated, "Just some of them. The aides are disrespectful. Some of			

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	the male aides are really rough and I can't handle that. They rush me. One male aide when he picks me up, he holds me too close and too tight. I would call it fondling." When asked "Do you feel the staff treats you with respect and dignity? For example, does staff take the time to listen to you and are staff helpful when you request assistance?", her response was, "No". During an interview with the Executive Director (E.D.) on 4/12/12 at 2:30 p.m., she indicated that some residents who were cognitively intact have a "prejudice" against those who have dementia. She indicated that the residents who are cognitively intact feel like the facility should remove the residents who are not cognitively intact. The E.D. indicated that the issue of wandering residents had been brought up in resident council meetings before and that she did indicate to the residents in the meetings they do have the right to wander and we could all be in that position some day. The E.D. indicated the facility offered stop signs or door bell alarms to alert when another person was coming in and the residents declined.			

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	The "Resident Council Agenda" for 6/2/11 was reviewed on 4/13/12 at 9:30 a.m. The agenda confirmed what the E.D. indicated at the time of the interview, it indicated that the residents declined to put up a stop sign or door alarm. 3.1-3(t)			

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F0249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. Based on record review and interview, the facility failed to ensure the Activity Director had completed a state approved course prior to taking the position and directing the activity program. This had the potential to affect all residents in the facility. Findings include: During a review of employee records on 4/16/12 at 1:00 p.m., documentation was not available regarding the training of the Activity Director. Further information was requested	F0249	**F249** **1. Corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.** No specific residents were identified in this deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by this deficient practice. As a corrective action, the employee currently holding this position will	05/17/2012

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	regarding documentation of the Activity Director's training from the Administrator on 4/16/12 at 2:30 p.m. During an interview with the Activity Director on 4/16/12 at 2:15 p.m., she indicated she was currently enrolled in a state approved course for Activity Directors. She provided documentation at this time to show she was enrolled in this course. In an interview with the Payroll Director on 4/17/12 at 4:00 p.m., she indicated the Activity Director started this position on 4/9/12. She indicated she had been part of the Housekeeping Department prior to being hired as the Activity Director. During an interview with the Administrator on 4/16/12 at 3:45 p.m., she indicated knowledge of the qualifications needed by the Activity Director, but she had spoken with a consultant at her corporate office and they thought the employee, after being hired for the position of Activity Director, had a year to complete a state approved course. 3.1-33(e)		have completed a State-approved activity director course by May 17, 2012. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** In the future, the activities program will be directed by a qualified professional. This will be monitored by our Human Resource Director to be sure they have the necessary qualifications. The HR Director has been inserviced on the correct qualifications for an Activity Director. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** Any new director hired into this position will meet State and Federal requirements upon hire. Upon hire, this person must be a: qualified therapeutic recreation specialist, licensed/registered activities professional, occupational therapist, occupational therapy assistant, or someone who has completed a State-approved course.	

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F0353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation and interview, the facility failed to provide sufficient nursing staff to meet the needs of all residents. This affected 9 of 40 sampled residents in a total sample of 132 residents residing in the facility. This affected Resident #'s 15, 80, 24, 123, 66, 3, 54, 104, and 129. Findings Include: 1. During an interview on 4/10/12 at 10:20 a.m., with Resident # 123, and in the presence of Resident #129, both residents indicated they feel like	F0353	**F 353 1. Corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.** There is adequate staff to provide necessary care and services to all residents. A resident council meeting will be held, with any residents who wish to attend, regarding their concerns surrounding sufficient staffing. In this meeting we will discuss how the building is staffed, expectations of staff and ways they can approach us if they have a staffing concern. Resident #123 has indicated she would like to be checked on more often due	05/17/2012

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	the facility does not have "enough help." The residents indicated there are not enough CNA's (Certified Nurses Aides) to help all residents get the assistance they need, including themselves. Resident #123 indicated that since she and her room mate are more independent than other residents, the nurses aides do not check on them as often as they should because they are so overwhelmed by residents that are no longer independent. Resident #123 indicated she has trouble breathing sometimes and would like to be checked on more often. During an observation on the afternoon of 4/11/12, and in the presence of the 400 Hall Unit Manager, Resident #129 was seen pushing Resident #44 in a wheel chair up the hall way to the nurses station. Resident #129 looked at the Unit Manager and stated "she was in our room" and turned to walk back to her room. Resident #129 and #123 are room mates and Resident #44 was taken out of their room to the nurses station by Resident #129. 2. During an interview on 4/11/12 at		to her condition, and the nurse aide assignment sheet was updated 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by this deficient practice. A nursing schedule and staffing ratio are reviewed daily. The DNS/Designee is responsible for ensuring adequate and sufficient staff to provide care to all residents. The 400 hall nurse aide assignments have been reassigned according to residents needs. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** A nursing schedule and staffing ratio are reviewed daily. The DNS/Designee is responsible for ensuring adequate and sufficient staff to provide care to all residents. The 400 hall nurse aide assignments have been reassigned according to residents needs. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** To ensure compliance, the DNS/Designee is responsible for completion of the sufficient staffing CQI tool, weekly x 4 weeks, bimonthly x 2 months,	

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	2:45 p.m., with Resident #66, she indicated there are not enough CNA's to provide residents with what they need. 3. During an interview with Resident #3 on 4/10/12 at 1:30 p.m., she indicated that the facility is "short staffed every day." She indicated they are very short of nurses aides. She also indicated there is consistently someone new working on the 400 unit every day because "they have a very large turn over" and "they work them very hard and short staffed." Resident #3 also indicated there are a lot of residents on the unit that require total care from nursing staff. 4. During an interview with Resident #54 on 4/11/12 at 9:20 a.m., she indicated that the facility is very short of help, "especially the aides," indicating the CNA's. Resident #54 also indicated there is a higher need for assistance for residents on the unit that require total care from nursing staff. 5. During an interview with Resident #104 on 4/10/12 at 2:30 p.m., she indicated that she feels like the facility is short staffed in regards to the CNA's and that not every resident		and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.	

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	gets the help they need when they need it. 6. During an observation of Resident #54 on 4/16/12 at 9:50 a.m., Resident #54 was visibly upset and indicated she was very upset because there was no one to assist her earlier that morning. She stated "we need an advocate around here, I'm gonna call it the do-it-yourself hospital!' She also said "They are so short handed around here I have been wet two times this morning and have had to have my clothes changed because there is no help." During an interview with LPN Employee # 2, on 4/16/12 at 11:00 a.m., she indicated that Resident #54 is normally continent of bladder and knows when she needs to use the restroom. During an interview with the Scheduling Coordinator and Director of Nursing (DON) on 4/17/12 at 11:00 a.m., they indicated they usually staff the 400 Hall (where all residents interviewed resided) with 4 CNA's during daytime and evening shift. They explained that at the time of the survey, there were 51 residents residing on the unit. They did indicate they would try to replace any shift or			

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	position that "called off." The DON indicated the people who were interviewed had a male CNA on their hall way and did not want to be taken care of by a man and for this, sometimes would have to wait for assistance. She indicated that they would let the man help for transfers, but not direct care and that's why the residents would have to wait for a female CNA. 7. On 4/9/12 at 3:35 p.m., an interview with Resident #15 indicated, "When we need help going to the bathroom, we have to wait awhile. Sometimes a long while. When I'm ready to go to bed I put on my light and then wait for someone to come help me get ready and get in bed. I usually wait awhile for that, too." 8. On 4/10/12 at 2:24 p.m., an interview with Resident #80 indicated she was routinely made to wait 45 minutes to an hour when she used her call light to request assistance. She was unable to identify specific names of staff and indicated concerns are during all shifts. She indicated the night shift was the worst and there were nights when no one came to check on her all night and she would be wet, from being incontinent, up to her neck by morning.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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	9. On 4/11/12 at 10:00 a.m., an interview with Resident #24 indicated "Sometimes I have to wait awhile before someone comes in to help me." She indicated all shifts were slow to respond to her call light. 3.1-17(a)			

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F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview, record review, and observation, the facility failed to identify and implement a plan of action for the identified concerns of resident dignity related to wandering residents and adequate staffing. This affected 9 of 40 sampled residents in a total census of 132 residents residing in the facility. Resident #s 123, 129, 66, 104, 54, 15, 80, 24, 3.	F0520	**520** **1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A QA process has been initiated to identify and implement a plan of action for the residents' concerns related to dignity and staffing.	05/17/2012

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	Findings Include: 1. During an interview on 4/10/12 at 10:20 a.m., with Resident #123, and in the presence of Resident #129, both residents indicated that they feel like the facility does not have "enough help." The residents indicated there are not enough CNA's (Certified Nurses Aides) to help all residents get the assistance they need. Resident #123 indicated that since she and her roommate are more independent than other residents, the nurses aides do not check on them very much because they are so overwhelmed by residents that are no longer independent. 2. During an interview on 4/11/12 at 2:45 p.m. with Resident #66, she indicated there are not enough CNA's to provide residents with what they need. 3. During ant interview with Resident #104 on 4/10/12 at 2:30 p.m., she indicated that she feels like the facility is short staffed in regards to the CNA's and that not every resident gets the help they need when they need it. 4. During an observation of Resident #54 on 4/10/12 at 9:50 a.m., Resident		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction actions will be taken?** All residents have the potential to be affected. A QA process has been initiated to identify and implement a plan of action for the residents' concerns related to dignity and staffing. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** In addition to our regularly scheduled QA topics, the resident council will be asked prior to any QA meeting to see if they have concerns regarding staffing. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur (i.e., what quality assurance program will be put into place?** A CQI tool for dignity and sufficient	

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	#54 was visibly upset and indicated she was very upset there was no one to assist her earlier that morning. She stated "We need an advocate around here, I'm gonna' call it the do-it- yourself hospital!" She also said "They are so short handed around here I have been wet two times this morning and have had to have my clothes changed because there is no help." During an interview with LPN, Employee #2, on 4/10/12 at 11:00 a.m., she indicated that Resident #54 is normally continent of her bladder and knows when she needs to use the restroom. 5. On 4/9/12 at 3:35 p.m., an interview with Resident #15 indicated, "When we need help going to the bathroom, we have to wait awhile. Sometimes a long while. When I'm ready to go to bed I put on my light and then wait for someone to come help me get ready and get in bed. I usually wait awhile for that, too." 6. On 4/10/12 at 2:24 p.m., an interview with Resident #80 indicated she was routinely made to wait 45 minutes to an hour when she used her call light to request assistance. She was unable to identify specific		staffing has been initiated and will be completed by Executive Director and/or designee. This tool will be completed 3 times a week for 2 weeks, weekly x 4 weeks then monthly x 3 months. This CQI tool will be reviewed through the Quality Assurance team monthly.	

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	names of staff and indicated concerns are during all shifts. She indicated the night shift was the worst and there were nights when no one came to check on her all night and she would be wet, from being incontinent, up to her neck by morning. 7. On 4/11/12 at 10:00 a.m., an interview with Resident #24 indicated "Sometimes I have to wait awhile before someone comes in to help me." She indicated all shifts were slow to respond to her call light. 8. During an interview with Resident #66 on 4/9/12 at 2:45 p.m., Resident #66 indicated that other residents (Residents #44 and 280) wander into her room any time they want and at times went through her belongings. She indicated that there are a couple of residents that wander from room to room, but that one resident (Resident #44) is constantly wandering. 9. During an interview with Resident #3 on 4/10/12 at 1:30 p.m., Resident #3, indicated there are people who have dementia, that are free to roam around the building that will wander into her room. Resident #3 indicated			

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	that she was particularly worried about Resident #44 because she has "tore up" things that belong to her, such as books and puzzles, and that she has knocked things on the floor when she has roamed into the room. Resident #3 also indicated that sometimes she is able to move Resident #44's wheelchair out of the room, but that Resident #44 can be very strong and sometimes won't move. Resident #3 indicated that at times it is "scary" when Resident #44 has roamed into her room because she is strong and doesn't know what she is doing. Resident #3 indicated that there have been times when Resident # 44 has roamed into her room in early morning hours while Resident #3 and her roommate were sleeping and it is "scary to wake up with someone wandering in your room and going through your stuff." Resident #3 indicated there was a time when Resident #44 hit her on the arm before and that there are times she will resist staff and other residents that try to remove her from a place she doesn't belong. Resident #3 indicated that Resident #280 does wander into her room often; however, she had the most "problems" with Resident #44. Resident #3 also indicated that the facility suggested a doorbell or stop sign to put on the			

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	door to try and keep residents that wonder out of rooms, but they didn't do it. Resident #3 also indicated that the facility told the residents "that could be any of us someday" and that the residents that wander around the building have the right to do so. 10. During an observation on the afternoon of 4/11/12, and in the presence of the 400 Hall Unit Manager, Resident #129 was seen pushing Resident #44 in a wheel chair up the hall way to the nurses station. Resident #129 looked at the Unit Manager and stated "she was in our room" and turned to walk back to her room. Resident #129 and #123 are room mates and Resident #44 was taken out of their room to the nurses station by Resident #129. 11. During an interview with the Executive Director (E.D.) on 4/12/12 at 2:30 p.m., she indicated that some residents who were cognitively intact have a "prejudice" against those who have dementia. She indicated that the residents who are cognitively intact feel like the facility should remove the residents who are not cognitively intact. The E.D. indicated that the issue of wandering residents had			

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	been brought up in resident council meetings before and that she did indicate to the residents in the meetings they do have the right to wander and we could all be in that position someday. The E.D. indicated the facility offered stop signs or doorbell alarms to alert when another person was coming in and the residents declined. The "Resident Council Agenda" for 6/2/11 was reviewed on 4/13/12 at 9:30 a.m. The agenda confirmed what the E.D. indicated at the time of the interview. During an Interview with the Executive Director (ED) on 4/17/12 at 11:30 a.m., indicated that deficiencies in the areas of adequate staffing were discussed more in the reference of time ratio, and resident dignity with the issue of wandering residents had been brought up in resident council meetings before, but had not been brought to the Quality Assurance Committee since January 2012. It was also indicated that the QA/A committee had not developed or implemented a plan of action to correct the indicated deficiencies. 3.1-52(b)(2)			

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